OHIO PHARMACISTS ASSOCIATION
2674 Federated Blvd., Columbus, OH 43235 • Phone: (614) 389-3236 • Fax: (614) 389-4582

Proponent Testimony for HB 465
Antonio Ciaccia
Director of Government & Public Affairs, Ohio Pharmacists Association

Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and members of the House Health Committee, my name is Antonio Ciaccia, Director of Government & Public Affairs for the Ohio Pharmacists Association (OPA). I thank you for the opportunity to give our support for HB 465, which will put the state of Ohio back in control of prescription drug spending through our Medicaid program.

In case you haven't heard from your local pharmacist, or in case you haven't read the approximately 70 pieces in the Columbus Dispatch over the last year, allow me to walk you through how billions of dollars in Ohio Medicaid's prescription drug program are actually being spent, and how Ohio has become ground zero for one of the biggest controversies in health care.

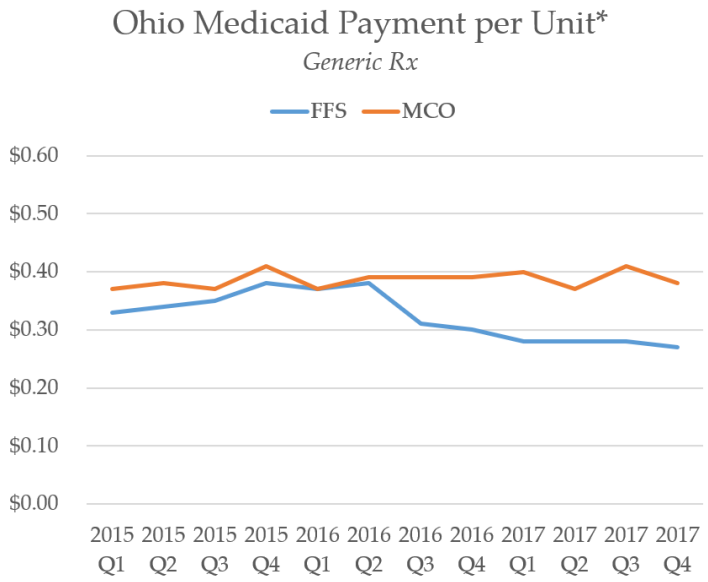
In the middle of 2016, I was inundated with calls and emails from panicked pharmacists who saw sweeping reimbursement cuts at their pharmacies through the Medicaid managed care program. Independent and chain pharmacies alike saw their gross margins on prescriptions chopped in half without any notice or change in contract terms from the managed care third party intermediaries, known as pharmacy benefit managers (PBMs). While taking losses on prescriptions is nothing new in pharmacy, the sheer volume and size of these cuts were unlike anything Ohio pharmacies had ever seen.

At the time, we sought answers from the Ohio Department of Medicaid and their managed care organizations (MCOs), but we came up short. Essentially, pharmacists were told that they needed to take the issues up to the PBMs that were administering the benefits for the MCOs. In Ohio, we have five MCOs. One has their own PBM called OptumRx, and the other four MCOs all contract with CVS/Caremark as their PBM.

After about a month or so without any reasonable explanations, reimbursements gradually increased, but they settled well below the rates that were in place before the cuts took place. What we learned after the fact was that in 2016, some contract changes between the MCOs and their PBM removed transparency and accountability in terms of what was actually being paid to pharmacies dispensing medications to Medicaid patients.

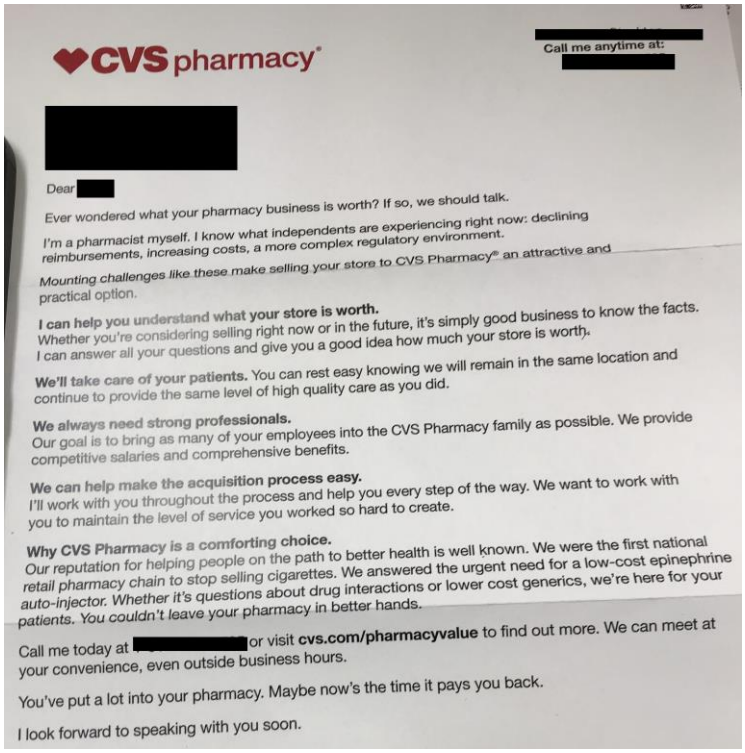
Effectively, at this point both CVS/Caremark and OptumRx, who own their own pharmacy businesses as well, had obtained an unchecked power to set the reimbursements to their own pharmacies, set the reimbursements to competitor pharmacies, and set the rates billed back to the state. Managed care organizations, who years ago argued that they wanted to carve in the pharmacy benefits so that they could drive better quality, improve outcomes, and control costs, instead outsourced the benefit to someone else – for-profit entities in the pharmacy business who had now been handed complete control of Ohio's Medicaid pharmacy marketplace. And unsurprisingly, pricing cuts and volatility ensued.

We decided to examine data from the Centers for Medicare and Medicaid Services (CMS) to see exactly what happened after PBMs gained complete, non-transparent control of the pharmacy program. We compared the rates being charged to the state (CMS's State Drug Utilization Database) through the Medicaid managed care program and the Medicaid fee-for-service program (where prices are transparent and fixed off of actual drug costs). What you'll see on the chart is that the prices being charged were generally similar up until the contract change in mid-2016. Drug prices in the fee-for-service program went down, but managed care stayed high. The MCOs' PBM pharmacy prices essentially became detached from reality.



In examining these data trends, it was alarming to learn that while drug prices were dropping and pharmacy margins were getting severely pressured , the state was not realizing the savings.

Over the course of the following year, pharmacists reported ongoing erosion of their margins from PBMs in the Medicaid managed care program, and then in August 2017, there was another wave of cuts. And then on October 26, 2017, the bottom fell out again. Sweeping cuts to local pharmacies threw the entire marketplace into chaos. Pharmacies weren't just losing money on a few drugs here and there, but at this point, if you averaged out all the drugs dispensed through the program, pharmacies were operating in the red in the aggregate – meaning they bought the medicine, dispensed it to the Medicaid patient, received no gross margin for the actual service, lost money on the drug itself, and then were left to figure out how to pay for their rent, utilities, software expenses, and of course, employees. Pharmacists reported that important addiction medications like generic Suboxone were being dispensed at $100 losses per prescription. It was a fiscal nightmare for Ohio pharmacies that was created literally overnight by this quick and easy change of rates by CVS – a change that had nothing to do with any changes in market prices of the underlying drugs.


CVS pharmacy

Call me anytime at: [redacted]

[redacted]

Dear [redacted]

Ever wondered what your pharmacy business is worth? If so, we should talk.

I'm a pharmacist myself. I know what independents are experiencing right now: declining reimbursements, increasing costs, a more complex regulatory environment.

Mounting challenges like these make selling your store to CVS Pharmacy® an attractive and practical option.

I can help you understand what your store is worth.
Whether you're considering selling right now or in the future, it's simply good business to know the facts. I can answer all your questions and give you a good idea how much your store is worth.

We'll take care of your patients. You can rest easy knowing we will remain in the same location and continue to provide the same level of high quality care as you did.

We always need strong professionals.
Our goal is to bring as many of your employees into the CVS Pharmacy family as possible. We provide competitive salaries and comprehensive benefits.

We can help make the acquisition process easy.
I'll work with you throughout the process and help you every step of the way. We want to work with you to maintain the level of service you worked so hard to create.

Why CVS Pharmacy is a comforting choice.
Our reputation for helping people on the path to better health is well known. We were the first national retail pharmacy chain to stop selling cigarettes. We answered the urgent need for a low-cost epinephrine auto-injector. Whether it's questions about drug interactions or lower cost generics, we're here for your patients. You couldn't leave your pharmacy in better hands.

Call me today at [redacted] or visit **cvs.com/pharmacyvalue** to find out more. We can meet at your convenience, even outside business hours.

You've put a lot into your pharmacy. Maybe now's the time it pays you back.

I look forward to speaking with you soon.

I was receiving complaints from nearly every pharmacy in the marketplace – big and small. The pharmacies I wasn't hearing from: CVS and OptumRx.

Making matters even more perplexing for pharmacists, is that in the midst of the most significant pharmacy reimbursement cuts from CVS/Caremark they had ever seen, CVS sent letters to Ohio pharmacy owners, soliciting to purchase their pharmacies, citing low reimbursements as the reason for long-time owners to leave their pharmacies "in better hands."

Again, as we sought answers and action from Medicaid and the managed care organizations tasked with managing the program, we were referred back to the very PBMs that were setting the unsustainable rates. Pharmacies meanwhile started laying off staff, pushing prescriptions out the door quicker, cutting services, and closing their doors.

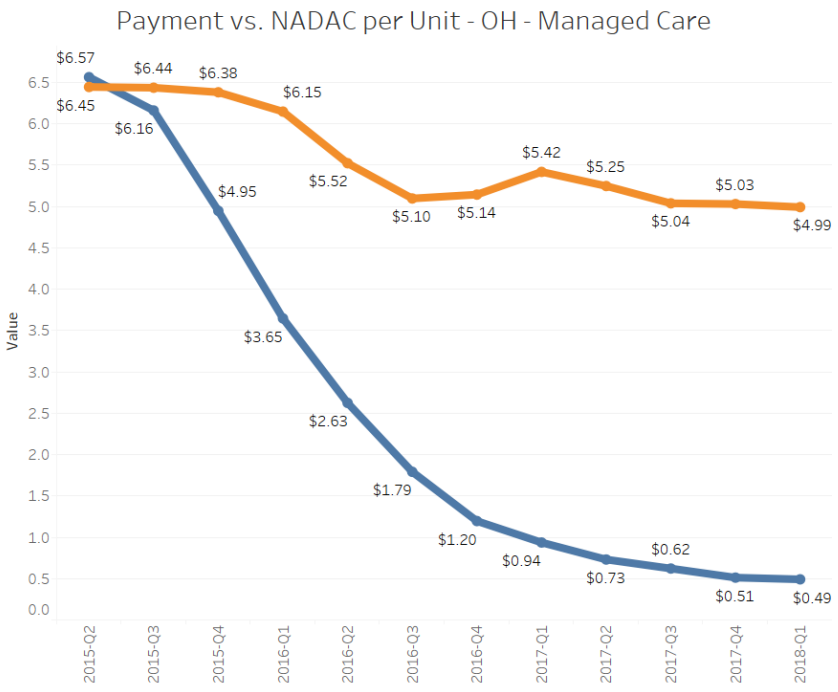
As the calls began pouring into the legislature, Medicaid eventually sought answers from the MCOs, who in turn referred Medicaid to CVS to discuss the cuts. They eventually capitulated and updated some prices, but overall, the cuts persisted. Over the course of a two-year stretch, pharmacies reported an overall 60-80% erosion of their gross margins in Medicaid managed care. Over that same time period, Ohio lost a net of 164 community pharmacies. As reported in the Columbus Dispatch, also over that time period, while most pharmacies saw a decline in locations, the top three pharmacy chains in terms of location growth were: Walgreens (+2), Ritzman (+3), and CVS (+68).

Meanwhile, at the January meeting of the Joint Medicaid Oversight Committee (JMOC), we learned from JMOC's actuaries that despite a rapidly deflating generic marketplace and pharmacy margin cuts of 60-80%, state spending on Medicaid managed care prescription drugs increased 22.5%. Ohio was paying a lot more for a lot less.

It was at this time that lawmakers like HB 465's sponsors, Rep. Scott Lipps and Rep. Kyle Koehler, along with many other lawmakers in both chambers and both parties began demanding answers. The Columbus Dispatch began digging in, and Ohio Auditor Dave Yost called for an audit of the program.

As reimbursements to pharmacies crept up slightly into April 2018, they remained well below the cost of the actual service, and these PBMs still controlled the dials for all drug spending in the Medicaid managed care program. Ohio lost another 13 pharmacies in just those three months.

As we awaited the results from Medicaid's analysis of the program, as well as the state audit, we started reviewing more CMS data, and we began comparing CMS State Utilization Data (what state Medicaid programs report to CMS as the cost of the drug) to National Average Drug Acquisition Cost – NADAC (the actual average pharmacy acquisition cost for drugs), and we found growing discrepancies between the actual prices of drugs versus what the state had been getting charged. The results were stunning.



Popular drugs like generic Nexium (Esomeprazole 40mg capsule, right) were deflating significantly in price, but Ohio went from having almost no markup to getting charged more than 10 times the actual cost of the drug.

While we cannot conclude that these markups are necessarily all being captured by the PBM, I can tell you that it PBM is the party that controls the decision on what to price to charge managed care for any given generic claim, which begs the question, "why?"

This is just one of hundreds of drugs that we've analyzed, but the tactic is not unique to Esomeprazole, and it is being exploited on a litany of generic drugs. Here are 20 notable drugs with markups of more than $20 per prescription from just the first quarter of this year:

Managed Care Medicaid Top 20 over $20

Choose State	Choose Year-Quarter
OH	2018-Q1

Top 20 Drugs in Managed Care with a markup over $20 per prescription, ranked by total Markup Dollars (Total Reimbursement - NADAC Ingredient Cost)

NDC Description	Markup Dollars	Markup per Script
BUPRENORPHINE-NALOXONE 8-2 MG SL TABLET	$3,099,299	$30.75
ARIPIPRAZOLE 5 MG TABLET	$2,037,176	$145.95
DULOXETINE HCL DR 60 MG CAP	$1,664,259	$40.02
ARIPIPRAZOLE 10 MG TABLET	$1,576,647	$145.54
ARIPIPRAZOLE 2 MG TABLET	$1,039,417	$154.24
GABAPENTIN 800 MG TABLET	$1,035,973	$21.64
OSELTAMIVIR PHOS 75 MG CAPSULE	$1,015,743	$24.59
HYDROXYCHLOROQUINE 200 MG TAB	$998,699	$104.17
DULOXETINE HCL DR 30 MG CAP	$881,450	$39.37
ARIPIPRAZOLE 15 MG TABLET	$856,202	$138.23
OMEPRAZOLE DR 20 MG TABLET	$819,151	$123.79
ARIPIPRAZOLE 20 MG TABLET	$768,964	$196.36
QUETIAPINE ER 400 MG TABLET	$630,135	$330.78
IMATINIB MESYLATE 400 MG TAB	$625,039	$5,482.80
QUETIAPINE ER 300 MG TABLET	$545,239	$242.76
DIVALPROEX SOD ER 500 MG TAB	$535,983	$53.82
DEXTROAMP-AMPHET ER 20 MG CAP	$532,176	$28.54
CELECOXIB 200 MG CAPSULE	$508,792	$73.58
DEXTROAMP-AMPHET ER 30 MG CAP	$497,815	$29.02
ARIPIPRAZOLE 30 MG TABLET	$491,313	$195.90

To reiterate, the "markup" is not what the PBM receives and not what the pharmacy receives. It is essentially the margin that the PBM and the pharmacy "share" on a claim (but note, it is not uncommon for the pharmacy to receive a negative margin, especially in Ohio managed care, meaning that in those instances, the PBM pockets all of the markup plus whatever they underpay the pharmacy).

That of course leads to the logical question of how markup is divvied up. That's where the state auditor's PBM report comes in, which was released in August of this year.

The report revealed that PBMs pocketed a whopping $224.8 million in hidden spread pricing (the difference between what the PBM pays pharmacies and what they bill the MCO/state) between Q2 2017 and Q1 2018 within the Ohio Medicaid managed care program, $208.4 million ($6.15 per prescription) which came from generic drugs.

While this is just one way that PBMs make money, in the context of spread, the question is, if PBMs pocketed $208.4 million on generic drugs in the Ohio Medicaid program, how much did pharmacies receive for actually dispensing those drugs? Applying a bit of arithmetic to the table on page 2 of the Auditor's report (placed below), we calculate that pharmacies received, on average, $13.40 per generic prescription (($662.7M - $208.4M) / 33.9M prescriptions).

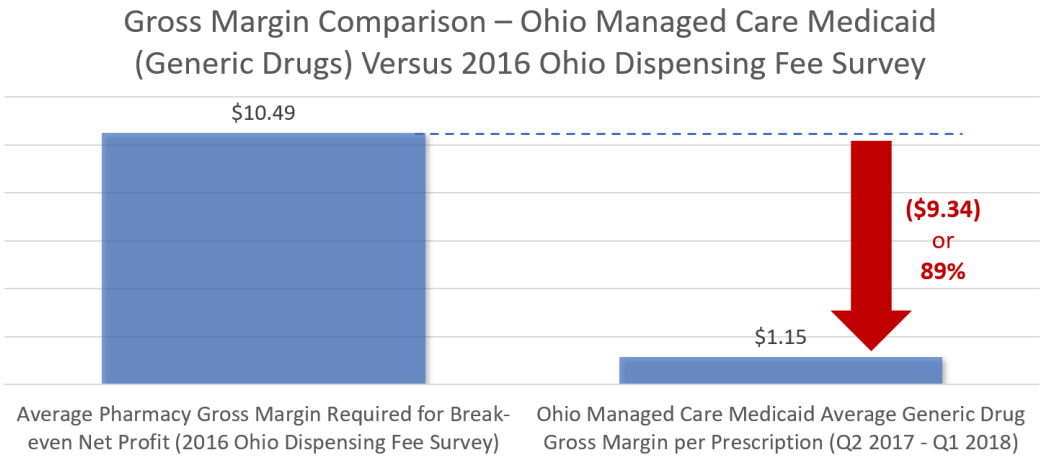
Average Spread by Quarter and by Drug Type from April 1, 2017 through March 31, 2018

Quarter	Average Spread			
	Brand	Generic	Specialty	Total Average Spread for All Claims
4/1/2017-6/30/2017	$2.11	$5.39	$30.12	$5.09
7/1/2017-9/30/2017	$2.03	$5.71	$31.91	$5.35
10/1/2017-12/31/2017	$1.57	$7.10	$31.24	$6.47
1/1/2018-3/31/2018	$1.62	$6.48	$46.04	$6.01
Yearly Total	**$1.85**	**$6.14**	**$33.49**	**$5.71**
	Brand	**Generic**	**Specialty**	**Totals**
Number of Prescriptions	**5,268,144**	**33,913,042**	**197,408**	**39,378,594**
Percentage of Claims	**13.4%**	**86.1%**	**0.50%**	**100%**
Amount Paid by Plans (millions)	**$1,246.1**	**$662.7**	**$617.6**	**$2,526.5**
Total Spread (millions)	**$9.8**	**$208.4**	**$6.6**	**$224.8**
Spread Relative to Total Paid Amount by Drug Type	**0.8%**	**31.4%**	**1.1%**	**8.9%**

To be clear, that $13.40/prescription is the total revenue that Ohio pharmacies received per prescription, not the pharmacy's gross margin per prescription. To estimate what the gross margin per prescription is for the pharmacy, we need to know the ingredient cost. In coordination with 46brooklyn Research, we ran an analysis of all generic oral solids that were dispensed over the course of the auditor's report and we factored in the NADAC price on every pill and capsule that Medicaid paid for over that time period. We then divided that by the total number of generic oral solid prescriptions dispensed over that time.

As shown below, the analysis showed a weighted average NADAC cost of $12.25 per prescription, meaning on average, out of the $13.40 per prescription that pharmacies received on generic drugs, pharmacies spent $12.25 per prescription in order to acquire those drugs from their distributors. Based on the data in Auditor Yost's report, this would leave an average Ohio pharmacy with a margin of only $1.15 per prescription. This margin is in stark contrast to Ohio's results from its own cost of dispensing survey, that aimed to capture the overall costs associated with operating a pharmacy and dispensing medications to patients. The most recent Ohio cost of dispensing survey (conducted in 2016) arrived at an average cost to dispense of $10.49 per prescription. This is the gross margin that Ohio Medicaid determined a pharmacy needs to cover its day-to-day operating costs (e.g. pharmacists, technicians, rent, utilities, pharmacy software, licensing, etc.). So we estimate that managed care Medicaid is falling short of Ohio Medicaid's own targeted dispensing fee by nearly 90% on generics.

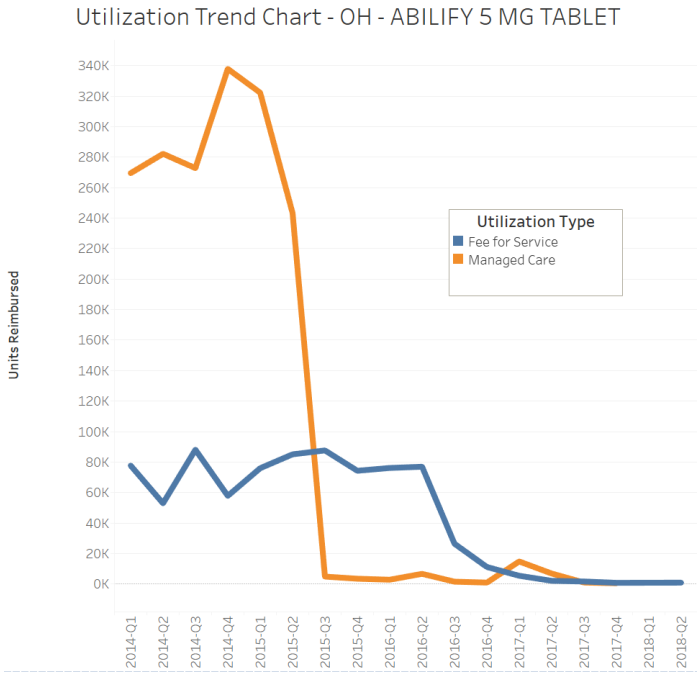
Ohio Managed Care Generic Drug Oral Solids Q2 2017 – Q1 2018	
Total NADAC Ingredient Cost	$362,883,182
Total Prescriptions	29,631,075
Weighted Average NADAC Ingredient Cost per Prescription	$12.25



Since nearly 85% of the drugs dispensed are generic drugs, you can see how quickly a pharmacy with high Medicaid volume can be knocked out of business. Even more alarming is the fact that while pharmacies were collecting $1.15 per prescription on generic drugs, PBMs that have their own pharmacies were pocketing the $6.15 per prescription spread on the other side of the transaction giving their overall companies a clear advantage over their competitors. And Medicaid's own commissioned report seems to validate these types of pharmacy numbers. According to their report, pharmacies were paid more than $350 million below typical market rates in Medicaid managed care. It's no wonder Ohio is watching pharmacies vanish.

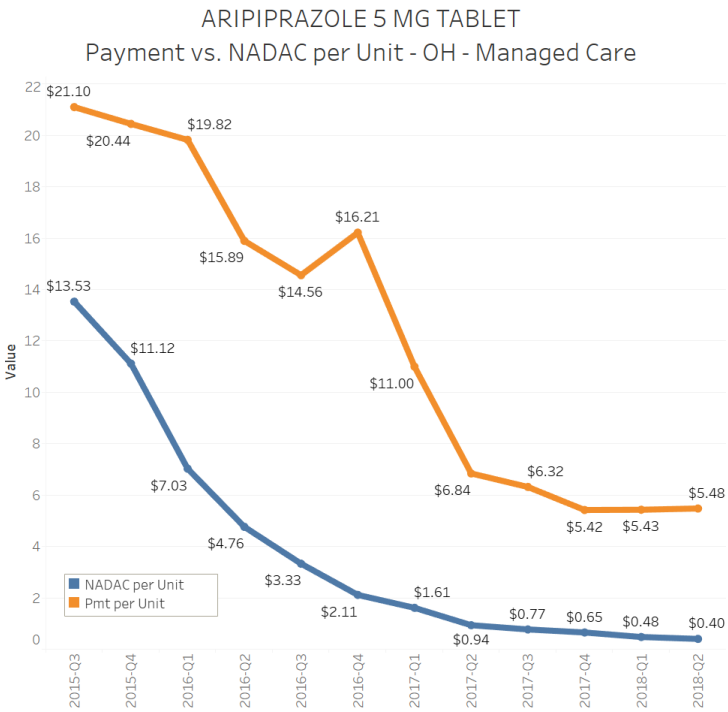
Unfortunately, this spread pricing mechanism that is at the heart of what has become a national controversy may not even be the most financially significant misaligned incentive in place within Medicaid managed care. Another very concerning misaligned incentive is rebates. The Medicaid Drug Rebate program mandates all drug manufacturers that produce drugs dispensed to Medicaid patients to commit to a sizable rebate program. The base rebate (or discount) for brand name, "innovator" drugs is 23.1% of the Average Manufacture Price. In addition to that, there is a CPI adjustment factor that ensures that the state and federal government will effectively never be charged for any more than an inflationary increase in any given year.

We modeled out the impact of these two factors alone. Let's assume that a manufacturer increased the list price of its brand name drug by 10% a year for the 10-year period of exclusivity left on its patent after years working to bring the drug to market. But inflation only increased 2% a year. By the time the generic is released in year 11, Medicaid would be collecting a 72% rebate on this drug. This means that for the state and federal government to save money, the generic would have to be priced at more than a 72% discount to the brand, but that rarely happens early in the life the generic.



However, both the PBM and the managed care organization have the economic incentive to control the Preferred Drug List to switch the state to the generic as quickly as possible. You can see this is exactly what happened with one of the most commonly dispensed mental health medications, generic Abilify (Aripiprazole 5mg), in late 2015 (right). We have already established that the PBM

makes loads of money off of generic spread, so switching to the generic shifts the price-setting capabilities to the PBM and allows the generic profit machine to start churning. And if you see what happened to the markup once generic utilization ramped up, that's exactly what happened (right).



So the question is how much money is the state losing out due to these misaligned incentives? While this is admittedly hard to quantify, we can look to MACStats, published by the Medicaid and CHIP Payment and Access Commission (MACPAC) for a hint. According to MACStats, in FY2016 gross drug spending in Ohio was $2.961 billion: $2.554 billion in managed care and $408 million in fee for service. Rebates on managed care were $1.273 billion or 49.8% of gross drug spending. On the other hand, rebates on fee for service were $247 million, or 60.5% of gross drug spending. In other words, fee for service produced more than 10 points of additional rebates when compared to managed care, an enormous number if we applied this to the more than $2.5 billion of managed care gross spending.

There are a lot of moving parts that need to be analyzed to do a full cost/benefit analysis, but it is very clear by analyzing the incentive structure that managed care may not be adequately incentivized to produce the lowest net costs for the state. That is a major problem. With a rebate program as rich as Medicaid's, we cannot simply use the rule of thumb to always dispense any available generic. We need the state to take back accountability of managing this process to provide the greatest benefits to its Medicaid members for the lowest net cost. Even when the state moves to a uniform preferred drug list (PDL), if the prescription program remains carved in, there will always be the incentive for managed care organizations and their PBMs to work around the state's PDL to extract more benefits for their shareholders..

While this is only a fraction of what I want to discuss, I realize that there is only so much appetite for drug pricing talk. And I can already anticipate a number of the counterpoints to my remarks, but I will remind this committee of a few things:

- The attrition of the pharmacy marketplace has still never been tackled in a meaningful way, despite the paltry access standards currently set within the program. It is difficult to hold anyone accountable if MCOs fail to meet the minimal access standards when prices drive providers out of business, because penalties are only able to be enforced when an *existing* provider is not "in-network." If there is no pharmacy, there's no access standard to enforce.

- At least two managed care plans directly profit themselves off of the pricing spreads, resulting in overinflated drug costs, and thus overinflated per-member-per-month rates from the state. This means that not only do the plans have the benefit of reaping the rewards of low-balling providers and reporting a higher price to the state, but they also get the added benefit that those overinflated prices can impact their per-member-per-month rates during the next budget cycle.

- The shift to managed care for any benefit is touted as a shift towards quality, innovative care models, integrated care, and value-based payments. Despite managed care organizations owning the pharmacy benefit for nearly a decade, aside from a couple programs, there has been little movement or progress on any of these fronts.

- MCOs and PBMs typically defend these issues by saying that despite many alarming examples, everything gets worked out in the aggregate. But the details matter. If the service being rendered to the patient, why should one drug have a markup of a few cents per tablet and another have a markup of $150 per tablet? This a massive red flag that someone may be gaming the system.

- Arbitrary drug pricing markups create warped incentives through the supply chain to dispense certain drugs over others, and as a result, serve some patients over others.

- By overinflating drug costs through spread pricing, plans have also shifted administrative costs into the medical portion of their medical-loss ratios that exist to ensure money received from the state is actually being spent on patient care. By artificially ballooning these pharmacy costs, managed care plans are afforded added real estate to increase their budgeting for administrative expenses and profits, while spending less on actual patient care.

- Any cost analysis of one system versus another must take into account a number of factors. Keep in mind, PBMs control the dials of every price and most decisions. There is a myriad of ways they can manipulate the current system, which makes cost comparisons of alternative models extremely difficult.

- PBMs largely capture the specialty drug marketplace in Medicaid managed care through their own pharmacies and restrict competitors from dispensing these expensive (and high-margin) medications. This space has the least transparency on markups, and it also happens to be the biggest cost-driver in the program. Any cost analysis for reform should factor in savings from exposing currently protected PBM market share to actual pharmacy competition.

- The state of West Virginia is the most recent state to carve out their pharmacy benefits from managed care, and they saved $38 million in their first year in a program approximately a fifth the size of Ohio's.

If you're not concerned about the long-term deleterious effects of this warped system, I will draw your attention back to your districts. The money being sucked out of pharmacies is coming right out of your communities and being shipped out of state to some of the wealthiest companies in the world. Your communities are losing needed healthcare providers, employers, and local tax revenue in the name of quarterly earnings for Wall Street.

With stories in the Wall Street Journal, NPR, Bloomberg, Axios and more now focusing on what's happening Ohio, we believe our state has the opportunity to get this system under control and be a model for other states looking to rein in drug spending. It comes down to this: what do you want to buy with your Medicaid prescription drug budget? Do you want to cover more medications? Do you want to cover more services? Do you want to create innovative care models? Do you want more local provider access points? Or do you want more expensive claims processors? If we want to drive true innovation to fully leverage the value that our state's pharmacists can bring to reducing overall health care expense (not just prescription expense), how will have any realistic hope of this coming to pass if the multiple MCOs and their PBMs that control the flow of money have no incentive to make this happen?

Managed care is supposed to be about unleashing the power and potential of competition to yield better quality and more efficient spending. In the context of pharmacy benefits, it's been the exact opposite. Rather than competing in an open market, MCOs partner up with their competitors under the umbrella of PBMs where they insulate themselves from competing with one another. Then the PBM uses their massive leverage to drive the market to the bone, meanwhile pocketing the savings for themselves and driving their competitors out of business.

Today, I give you this testimony amidst another arbitrary wave of cuts from PBMs in the Medicaid managed care program that as of last month essentially brought pharmacies back to the same levels they were at last year. Despite all of the attention and heat, the market hasn't moved an inch, and taxpayers are again footing the bill for this latest PBM cash-grab. It is impossible to run a functioning business and healthcare practice in this type of environment, and I fear what is being lost at the pharmacy counter beyond just boarded up practices.

Our Medicaid Department has begun working towards a solution to this mess, but my fear is that the current proposed solutions of transparency will only tell us what we already know: PBMs are taking advantage of our providers and our state. That is now abundantly clear, and so now the questions are, how do we make it stop, and what type of program do we build in its place?

While I come before this committee on behalf of the Ohio Pharmacists Association to end the crippling cuts at the pharmacy counter, I also ask that that you take the wheel of a program that has veered far off the rails. PBMs have taken control of this program, and it is time for the state to take it back.

The Ohio Pharmacists Association applauds the work of our sponsors, Reps. Lipps and Koehler for their steadfast support, as well as several members of this committee who have rolled up their sleeves on this issue over the past year. We would also like to thank the Columbus Dispatch and their work through their special Side Effects series, which has moved the public discourse on this complicated issue light years from where it was before they started their reporting. I'd lastly like to thank the Department of Medicaid for their work – we did not start out seeing eye-to-eye on these issues, but I believe they have done a remarkable job getting up to speed and tackling this issue head on in recent weeks. While their ideas for policy fixes may not be the same as our association's, the fact that they are engaging meaningfully has me hopeful that this system will change somehow in the future.

Thank you for the opportunity to give our support for HB 465, and I'll happily answer any questions you may have.

Antonio Ciaccia
Ohio Pharmacists Association
aciaccia@ohiopharmacists.org